CHAPTER VI

BILLING INSTRUCTIONS

CHAPTER VI
TABLE OF CONTENTS

CHAPTER VI
TABLE OF CONTENTS

CHAPTER VI
BILLING INSTRUCTIONS

RATES OF REIMBURSEMENT FOR PERSONAL CARE SERVICES

To comply with federal and State mandates, a ceiling for the cost of personal care services has been calculated for regions of the State and must be applied uniformly on a statewide basis, according to geographical locality. The fee for personal care services is an hourly fee which relates to the time the aide is actually in the home. This fee must cover all expenses associated with the delivery of personal care services including nursing visits. The hourly reimbursement rate is considered by DMAS as payment in full for all administrative overhead and other administrative costs that the provider agency incurs. The personal care hourly reimbursement rate is:

Elderly and Disabled Waiver	$11.00 per hour in Northern Virginia $9.00 per hour Rest of the State [Effective January 1, 1992]
AIDS/ARC Waiver	$12.50 per hour in Northern Virginia $10.80 per hour Rest of the State

The Northern Virginia localities are:

Alexandria	Arlington
Fairfax City	Fairfax County
Falls Church	Loudoun County
Manassas	Manassas Park
Prince William County	

The maximum number of hours which can be billed is the amount included on the agency's approved Plan of Care.

Only whole hours can be billed. If an extra 30 or more minutes of care are provided, the next highest hour can be billed. If less than 30 extra minutes of care are provided, the next lower number of hours must be billed. Provider agencies may only bill for services one time each month per recipient.

RATES OF REIMBURSEMENT FOR RESPITE CARE SERVICES

To comply with federal and State mandates, a ceiling for the cost of respite care services has been calculated and must be applied uniformly based on the geographical locality of the provider. The unit of service for respite care will be defined by the number of hours of service which are provided.

An hourly reimbursement will be made for services not in excess of eight hours in one 24-hour period. The hourly reimbursement rate for respite care services provided by a respite care aide is:

Elderly and Disabled Waiver	$11.00 per hour in Northern Virginia $ 9.00 per hour Rest of the State
AIDS/ARC Waiver	$12.50 per hour in Northern Virginia $10.80 per hour Rest of the State

When skilled services are offered (as authorized) by a licensed practical nurse, the hourly rate of reimbursement is:

Elderly and Disabled Waiver	$12.50 per hour in Northern Virginia $12.00 per hour Rest of the State
AIDS/ARC Waiver	$26.00 per hour in Northern Virginia $19.00 per hour Rest of the State

A per diem reimbursement rate will be used for services provided to elderly and disabled recipients whose care is in excess of eight hours in a 24-hour period. (A per diem reimbursement is not made for AIDS Waiver recipients.) The per diem reimbursement rate is:

Respite Care Aide Services	$110.00 per diem in Northern Virginia $ 90.00 per diem Rest of the State
Respite Care LPN Services	$125.00 per diem in Northern Virginia $120.00 per diem Rest of the State

This reimbursement must cover all expenses associated with the delivery of respite care services. The respite care provider cannot charge the Department of Medical Assistance Services a higher rate for respite care services rendered to Medicaid recipients than is charged the private sector for a comparable service.

The amount of respite care services required by each recipient shall be determined by the Pre-Admission Screening Committee. This authorization for units of service will establish the maximum number of units and the allowable payment for the service. Provider agencies may only bill for services one time each month.

PATIENT PAY AMOUNT AND COLLECTION

Patient pay is that amount of a Medicaid recipient's income that must be contributed to the cost of his or her care. The amount of patient pay is determined by the Department of Social Services eligibility worker based on the recipient's income and medically related deductions. It is the responsibility of the Department of Social Services to notify the recipient and the provider agency of any change in patient pay amount. Patient pay ~~estimates~~ are obtained by Screening Committees to inform the recipient of the estimated patient pay amount. The provider agency should immediately initiate a DMAS-122 form and send it to the local Department of Social Services upon accepting a referral for personal care so that the Department of Social Services can notify the provider agency of the actual patient pay amounts. The provider should compare these actual figures against the Screening Committee's estimates. If the two do not correspond, the provider should notify the recipient of the patient pay amount on the DMAS-122 and bill DMAS accordingly.

Upon receipt of a referral in which a patient pay amount for personal care is indicated, the provider agency should verify that the recipient understands and agrees to his or her patient pay obligations. Medicaid suggests that this verification be in the form of a signed statement of obligation and that the patient pay amount be collected at the first of the month. It is the responsibility of the provider agency to collect the patient pay amount. DMAS will not reimburse the provider agency for any portion of the patient pay amount.

The personal care agency has total patient pay collection responsibility for individuals who have a patient pay responsibility and who have been approved for both adult day health care and personal care. In those instances where the patient pay responsibility usually exceeds the amount of personal care services authorized, the personal care agency will divide the amount of patient pay so that the statement obligation signed by the participant indicates the amount the participant will pay monthly to the adult day health care center and the amount the participant will pay monthly to the personal care agency.

In the event that the recipient does not pay the patient pay amount in a timely manner, the provider must make a reasonable effort to notify the recipient/family of the situation in an effort to collect the required amount. A reasonable effort shall be defined as three written notifications to the recipient with copies sent to DMAS.

The recipient's failure to pay the patient pay amount might affect his or her Medicaid eligibility. Therefore, if the personal care agency is unable to collect the patient pay amount, the personal care agency must also notify the local Department of Social Services eligibility worker having case responsibility for the recipient. This notification must be in writing and a copy retained in the recipient's record in the personal care provider agency. It is the personal care agency's responsibility to collect patient pay and to decide whether to continue service delivery to a recipient who neglects to pay his or her patient pay. DMAS will not reimburse the agency for the patient pay amount.

If, after a reasonable effort to collect the patient pay amount, the personal care provider agency decides to terminate personal care services, the provider agency must give the recipient/family five days' written notification which includes the reason for termination and the effective date. A copy of this notification must be sent to the local Department of Social Services eligibility worker. A copy of all correspondence must be retained in the recipient's record in the personal care provider agency and a copy sent to DMAS.

Patient pay is the recipient's contribution toward his or her care received in a calendar month. If the amount of care received in a month by a recipient is less than the patient pay amount, only the amount of services rendered should be collected from the recipient. If the amount of services rendered is equal to or less than the recipient's patient pay amount, DMAS should not be billed for that month. If the amount of services rendered is greater than the amount of patient pay, an invoice should be submitted showing the total allowable charges and patient pay amount. The provider agency will be reimbursed for the total allowable charges less the patient pay amount.

Any time a new DMAS-122 is received, it is the provider agency's responsibility to note any changes in the amount to be collected from the recipient and bill accordingly.

MEDICAID BILLING INVOICES

Personal Care

The use of the appropriate billing invoice depends upon the type of billing transaction being completed. Listed below are the two billing forms that are used for personal care. Examples of these forms are included in this chapter.

- Personal Care Invoice, DMAS-93; and
- Personal Care Adjustment Invoice, DMAS-94.

Respite Care

The billing invoice for respite care is the HCFA-1500 (12/90).

SUBMISSION OF BILLING INVOICES

Agencies must submit claims using the actual dates of service rendered within a calendar month. Agencies may only bill for services once per month. Invoices must include only allowable charges for the number of hours for services rendered during the calendar month. Any charges submitted **prior** to the date authorized by the Screening Committee as the begin date will be rejected. Invoices must be submitted in the purple-edged, self-addressed envelope provided by DMAS. The provider copy of the invoice must be retained by the provider for record-keeping. All invoices must be mailed with proper postage; messenger or hand deliveries will not be accepted. Invoices and adjustments should never be mailed to the Department of Medical Assistance Services address; this will only delay processing. Provider agencies should allow at least 30 days for claims processing.

TIMELY FILING OF CLAIMS FOR PERSONAL CARE SERVICES

Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 15 days from the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely fashion, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local Department of Social Services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

  The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the letter from the local Department of Social Services indicating the delayed claim information must be attached to the appropriate claim. If the claim is filed on the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** - Rejected or denied claims which have been submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the invoice as explained under the Instructions for Completion of the Department of Medical Assistance Services Invoice, DMAS-93, found elsewhere in this chapter.

  - Explain the reason for the late submission in the Remarks section of the invoice and **attach** written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

    Department of Medical Assistance Services
    Personal Care Services
    P. O. Box 25507
    Richmond, Virginia 23261

The first copy of a multicopy invoice form should be submitted in the preaddressed Medicaid envelope. The additional copies are retained by the provider for record-keeping. All invoices must be mailed (proper postage is the responsibility of the provider and will help prevent mishandling); messenger or hand deliveries will not be accepted.

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt, except in the following circumstances:

  - The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

  - The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

  - This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

  - The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those directly affected by it.

The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of these specified criteria.

TIMELY FILING OF THE HCFA-1500 (12-90) FOR RESPITE CARE

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the date of the last date of service or discharge. Federal financial participation is not available for claims which **are not** submitted within 12 months from the date of the service. Medicaid is not authorized to make payment on these late claims, except under the following conditions:

- **Retroactive Eligibility** - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely manner, billing will be handled in the same manner as for delayed eligibility.

- **Delayed Eligibility** - Medicaid may make payment for services billed more than 12 months from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for a recipient whose eligibility has been delayed. When the provider did not have knowledge of the Medicaid eligibility of the person prior

to rendering the care or service, he or she has 12 months from the date he or she is notified of the Medicaid eligibility in which to file the claim. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local Department of Social Services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted.

The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the receipt of the notification of the delayed eligibility. A copy of the letter from the local Department of Social Services indicating the delayed claim information must be attached to the claim. On the HCFA-1500 (12-90) form, enter "ATTACHMENT" in Locator 10d and indicate "Unusual Service" by entering Procedure Modifier "22" in Locator 24D.

- **Rejected or Denied Claims** - Rejected or denied claims submitted initially within the required 12-month period may be resubmitted and considered for payment without prior approval from Medicaid. The procedures for resubmission are:

  - Complete the HCFA-1500 (12-90) invoice as explained under the Instructions for the Use of the HCFA-1500 (12-90) Billing Form elsewhere in this chapter.

  - Attach written documentation to verify the explanation. This documentation may be photocopies of invoices or denials by Medicaid or any follow-up correspondence from Medicaid showing that the claim was submitted to Medicaid initially within the required 12-month period.

  - Indicate Unusual Service by entering "22" in Locator 24D of the HCFA-1500 (12-90) claim form.

  - Submit the claim in the usual manner using the preprinted envelopes supplied by Medicaid or by mailing the claim to:

    Department of Medical Assistance Services
    Practitioner
    P. O. Box 27444
    Richmond, Virginia 23261-7444

Submit the original copy of the claim form to Medicaid. Retain a copy for record keeping. All invoices must be mailed; proper postage is the responsibility of the provider and will help prevent mishandling. Envelopes with insufficient postage will be returned to the provider. **Messenger or hand deliveries will not be accepted.**

- **Exceptions** - The state Medicaid agency is required to adjudicate all claims within 12 months of receipt except in the following circumstances:

- The claim is a retroactive adjustment paid to a provider who is reimbursed under a retrospective payment system.

- The claim is related to a Medicare claim which has been filed in a timely manner, and the Medicaid claim is filed within six months of the disposition of the Medicare claim.

- This provision applies when Medicaid has suspended payment to the provider during an investigation and the investigation exonerates the provider.

- The payment is in accordance with a court order to carry out hearing decisions or agency corrective actions taken to resolve a dispute or to extend the benefits of a hearing decision, corrective action, or court order to others in the same situation as those affected by it.

- The procedures for the submission of these claims are the same as previously outlined. The required documentation should be written confirmation that the reason for the delay meets one of the specified criteria.

- **Accident Cases** - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, no reimbursement can be made by Medicaid as the time limit for filing the claim has expired.

REMITTANCE VOUCHER (Payment Voucher)

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a listing of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five years.

The remittance voucher includes an address location which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward Virginia Medicaid payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address to allow the provider files to be updated.

The remittance voucher's first page contains space for special messages from DMAS. Providers are encouraged to monitor the remittance vouchers for these special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to Virginia Medicaid policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

PREAUTHORIZED SERVICES FOR RETROACTIVE ELIGIBILITY

For services requiring preauthorization, all preauthorization criteria must be met for the claim to be paid. For those services occurring in a retroactive eligibility period, after-the-fact authorizations will be performed by DMAS.

PATIENT INFORMATION FORM (DMAS-122)

Purpose

This form is used by a local Department of Social Services and a personal care provider to exchange information with respect to:

- The responsibility of an eligible recipient to make payment toward the cost of care;
- The admission or discharge of the recipient or death of the recipient; and
- Other information known to the provider that might involve a change in eligibility or patient pay responsibility.

The form shall be prepared by the provider to request a Medicaid number, eligibility determination, or confirmation of patient pay or to notify the local Department of Social Services of changes in the recipient's circumstances. A new form must be prepared by the local Department of Social Services at the time of each redetermination of eligibility and whenever there is any change in the recipient's circumstances that results in a change in the amount of the patient pay.

Disposition of Copies

The provider should initiate the form upon receiving a referral from the Pre-Admission Screening Committee in order to notify the local Department of Social Services that he or she has admitted the recipient and to provide the beginning date of service. Upon determination of eligibility, the DMAS-122 will be returned to the provider agency with the following information:

- Whether the recipient does or does not have financial responsibility toward the cost of care;
- The amount and sources of finances; and
- The date on which the patient pay responsibility begins.

There must be a completed DMAS-122 form in the recipient's file prior to billing DMAS.

REQUESTS FOR BILLING MATERIALS AND ALL FORMS USED BY PROVIDER AGENCIES

The Department of Medical Assistance Services "Request for Forms/Brochures" (DMAS-161) or "Request for Billing Supplies" (DMAS-160), as appropriate, must be used by providers when the DMAS-90, DMAS-93, DMAS-94, DMAS-89, DMAS-97A, DMAS-122, or DMAS-659 forms are ordered. (Examples of these ordering forms are included as Exhibits VI.1 and VI.2.) A six-month supply of forms should be ordered at least three (3) weeks prior to the anticipated need.

The "Request for Forms/Brochures" or "Request for Billing Supplies" must be submitted to:

DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

Any requests for information or questions concerning the ordering of forms should also be sent to the address above or by calling: (804) 329-4400.

The HCFA-1500 (12-90) can be obtained from the U.S. Government Printing Office. Specific details on purchasing can be obtained by writing to the following address:

U.S. Government Printing Office
Superintendent of Documents
Washington, D.C. 20402

In addition, many local forms printers also supply this form. Please contact the printer of choice for further information.

The Client Materials Management Unit of the Department of Medical Assistance Services is responsible for the distribution of all forms issued by DMAS.

INQUIRIES CONCERNING BILLING PROCEDURES

Inquiries concerning covered benefits, specific billing procedures, or remittances should be directed to the Medicaid HELPLINE number:

786-6273 Richmond Area
1-800-552-8627 All Other Areas

The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except on State holidays.

EXHIBIT VI.1

REQUEST FOR BILLING SUPPLIES (DMAS-160)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR BILLING SUPPLIES

Name_____ Date _____

Provider Number_____ Contact Person _____

Telephone # (_____) _____
(Area Code)

Check As Appropriate

_____ Please forward preprinted invoices as indicated below.
_____ Please forward invoices suitable for computer use as indicated below.
_____ Other (See Order Below)

Quantity:	Dental:
_____	DMAS-701 Invoice
_____	DMAS-702 Invoice Adjustment
_____	DMAS-704 Preauthorization Req
_____	DMAS-703 Envelope
	Home Health Agency:
_____	DMAS-662 Envelope
	Hospital:
_____	DMAS-660 Envelope
	Laboratory:
_____	DMAS-123 Invoice
_____	DMAS-230 Invoice Adjustment
_____	DMAS-665 Envelope
	Nursing Home:
_____	DMAS-215 Invoice
_____	DMAS-262 Invoice Adjustment
_____	DMAS-661 Envelope
	Personal Care: NOT PREPRINTED
_____	DMAS-93 Invoice
_____	DMAS-94 Invoice Adjustment
_____	DMAS-659 Envelope

Quantity:	Pharmacy:
_____	DMAS-173 Drug Claim Ledger
_____	DMAS-228 Drug Claim Adjustment
_____	DMAS-664 Envelope
	Practitioner:
_____	DMAS-663 Envelope
	Screening (EPSDT):
_____	DMAS-663 Envelope
	Special Service: NOT PREPRINTED
_____	DMAS-199 Invoice
_____	DMAS-233 Invoice Adjustment
_____	DMAS-666 Envelope
	Title XVIII: NOT PREPRINTED
_____	DMAS-30 (Medicare) Deductible and Coinsurance Invoice
_____	DMAS-31 Invoice Adjustment
	Transportation: NOT PREPRINTED
_____	DMAS-7 Invoice
_____	DMAS-8 Invoice Adjustment
_____	DMAS-666 Envelope

Please return this form to: DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

DMAS-160 R 3/92

EXHIBIT VI.2

REQUEST FOR FORMS/BROCHURES (DMAS-161)

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
REQUEST FOR FORMS/BROCHURES

Name_____ Date _____

Provider Number_____ Contact Person _____

Telephone # (_____) _____
(Area Code)

Quantity	Form Number	Form Name
_____	DMAS-9	Verification of Non-Emergency Transportation Form
_____	DMAS-13	Medicaid Driver Registration Form
_____	DMAS-16	Maternity Risk Screen
_____	DMAS-17	Infant Risk Screen
_____	DMAS-20	Consent Form for Release of Information Rev 1/90
_____	DMAS-50	Maternal Care Coordinator Record (25/pad)
_____	DMAS-51	Infant Care Coordinator Record (25/pad)
_____	DMAS-52	Care Coordination Service Plan (25/pad)
_____	DMAS-53	Pregnancy Outcome Report (25/pad)
_____	DMAS-54	Infant Outcome Report (25/pad)
_____	DMAS-55	Care Coordination Letter of Agreement (25/pad)
_____	DMAS-70	Practitioner Referral Form
_____	DMAS-77	ICF/MR Utilization Review Assessment
_____	DMAS-77A	Programs/Objective Continuation Sheet
_____	DMAS-80	Patient Intensity Rating System Review (50/pad)
_____	DMAS-80A	Personal Care Utilization Review
_____	DMAS-89	Personal Care Recipient Admissions Envelope
_____	DMAS-90	Personal Care Aide Record
_____	DMAS-95	Assessment Process
_____	DMAS-95MI/MR	Supplemental Assessment Process Form
_____	DMAS-96	Nursing Home Pre-Admission Screening Plan
_____	DMAS-97	Plan of Care for Personal Care Services (25/pad)
_____	DMAS-97A	Provider Agency Plan of Care (25/pad)
_____	DMAS-98	Documentation of R.N. Supervisory Visit (25/pad)
_____	DMAS-99	Recipient Progress Report
_____	DMAS-113A	Medicaid HIV Services Pre-Screening
_____	DMAS-113B	Medicaid HIV Waiver Services Plan of Care
_____	DMAS-114	Medicaid HIV Services Case Management Plan
_____	DMAS-119	Social History Form
_____	DMAS-121	Certificate of Patient Status
_____	DMAS-121-A	Certificate of Patient Rehabilitative Services
_____	DMAS-122	Patient Information(25/pad)
_____	DMAS-125	Rehabilitation Treatment Authorization (Intensive Rehab only)
_____	DMAS-200	Appeal to Medical Assistance Appeals Board
_____	DMAS-212	Title XIX Enrollment(50/pad)
_____	DMAS-300	Respite Care Needs Assessment and Plan of Care
_____	DMAS-301	Adult Day Health Interdisciplinary Plan of Care
_____	DMAS-302	Adult Day Health Care Daily Log
_____	DMAS-351	Preauthorization Request
_____	DMAS-353	EPSDT Documentation Form
_____	DMAS-403	Title XIX Admission Certification Psychiatric Hospital
_____	DMAS-412	Medicaid Request for Psychiatric Extension Treatment(25/pad)
_____	DMAS-420	Request for Hospice Benefits
_____	DMAS-421	Hospice Benefits Revocation/Change Statement
_____	DMAS-999	Third Party Liability Information Report
_____	DMAS-1000	Third Party Liability Information Report
_____	DMAS-3004	Sterilization Consent Form
_____	DMAS-3005	Acknowledgement of Receipt of Hysterectomy Information
_____	DMAS-3006	Abortion Certification
_____	DMAS-4000	Prosthetic Device Preauthorization Form

Quantity	Form Number	Brochure Name
_____	DMAS-1	Medicaid Health Checkup Program
_____	DMAS-2	Virginia Medicaid Handbook
_____	DMAS-4	"Spend-Down" Sheet
_____	DMAS-60	BabyCare (English)
_____	DMAS-61	BabyCare (Spanish)
_____	DMAS-62	BabyCare (Vietnamese)
_____	DMAS-63	BabyCare (Laotian)
_____	DMAS-64	BabyCare (Cambodian)
_____	DMAS-66	Emergency Care
_____	DMAS-67	Planning Ahead: A Guide for Virginians with Disabilities

Please return this form to: DMAS Order Desk
North American Marketing
3703 Carolina Avenue
Richmond, Virginia 23222

DMAS-161 R 3/92

INSTRUCTIONS FOR COMPLETION OF THE PERSONAL CARE INVOICE (DMAS-93)

If omitted or entered incorrectly, any single item of the following will cause the invoice to reject or deny. A rejected or denied invoice must be completely redone and resubmitted by the provider agency. See Exhibit VI.3 for a sample copy of the DMAS-93.

Block 1 **Transmission Code** - Preprinted on the invoice.

Block 2 **Provider ID Number** - The provider identification number is a seven-digit number assigned by DMAS. If not preprinted, enter the appropriate identification number and, above it, the name and address of the provider agency.

Block 3 **Recipient ID Number** - The recipient eligibility number is a 12-digit number which can be obtained from the recipient's eligibility card. It must be entered accurately on the invoice. The eligibility number should be written as follows:

123-456789-01-2

Block 4 **Recipient Name** - Enter the recipient's full name, as shown on the recipient eligibility card, with the last name entered first, followed by the first name.

Block 5 **Account Number Assigned by Provider** - Optional

Block 6 **Primary Carrier Information** - Omit

Block 7 **Date Care Began** - Enter the date personal care services were first provided during this enrollment period even if the recipient transferred from one agency to another without termination of personal care services.

Block 8 **Statement Covers Period** - Using six-digit dates, enter the beginning date of this service (from) and the last date of this service (through). Bill only for services provided during a calendar month.

Example:

Mo.	Day	Year	Mo.	Day	Year
07	01	93	07	31	93

Block 9 **Discharge Status** - Check the applicable box.

Block 10 **Pre-Authorized Hours Per Month** - Enter the number of hours authorized on the Plan of Care (DMAS-97 or DMAS-87) which corresponds to the month of the bill.

Block 11 **Statement of Services Rendered** - The number of hours of service provided during a billing period (one month) and the total charges for these hours must be entered in line F only. The total charges must agree with the number of hours multiplied by the basic fee. Omit the shaded lines A-E and G-I. These items do not apply to personal care services.

Block 12 **Total Covered Charge** - Enter the amount from Line 11-F.

Block 13 **Amount Paid by Recipient** - Enter the dollar amount of the recipient payment as shown on the DMAS-122. Do not bill DMAS when the patient pay amount is equal to or greater than the amount charged. The recipient is responsible for this amount and should be billed. Even if the patient pay amount has not been collected, the amount that should be paid by the client must be entered.

Signature and Date The person completing the form must sign the invoice. The date should be the date of mailing to the Fiscal Agent.

EXHIBIT VI.3

PERSONAL CARE INVOICE (DMAS-93)

PERSONAL CARE INVOICE

VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

1 TRANSMISSION CODE 041 | 2 PROVIDER I.D. NUMBER (7) | 3 RECIPIENT I.D. NUMBER (12) | 4 RECIPIENT'S LAST NAME | FIRST NAME

5 PATIENT ACCOUNT NUMBER (10) | 6 PRIMARY CARRIER INFORMATION (CHECK ONE) 2 ☐ NO OTHER COVERAGE 3 ☐ BILLED AND PAID 5 ☐ BILLED, NO COVERAGE

7 DATE CARE BEGAN MO. DA. YEAR | 8 FROM MO. DA. YEAR THRU MO. DA. YEAR | 9 DISCHARGE STATUS (CHECK ONE) 1 ☐ DISCHARGED 2 ☐ DIED 3 ☐ STILL A PATIENT | 10 PRE-AUTHORIZED HOURS PER MONTH(S)

11 STATEMENT OF SERVICES RENDERED

	HOURS	CHARGE
C SKILLED NURSING CARE		
A PHYSICAL THERAPY		
C SPEECH THERAPY		
D OCCUPATIONAL THERAPY		
E MEDICAL SOCIAL SERVICES		
F PERSONAL CARE AIDE		
G OTHER VISITS		
H SUPPLIES		
I RENTAL-MEDICAL EQUIPMENT		
12 TOTAL COVERED CHARGE		
13 AMOUNT PAID BY RECIPIENT		

REMARKS

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

SIGNATURE DATE

INSTRUCTIONS FOR COMPLETION OF ADJUSTMENT INVOICES (DMAS-94)

Occasionally, it may be necessary to take corrective action for a billing previously submitted to DMAS. This action is accomplished by the submission of the Adjustment Invoice. **Adjustment Invoices can only be submitted for claims that have been paid.** See Exhibit VI.4 for a copy of the DMAS-94.

The Personal Care Adjustment Invoice is similar to the Personal Care Invoice used by provider agencies and requires the same degree of accuracy in completion.

Block 1	**Adjustment/Void** - Check the appropriate block. See the reasons for adjustment and the reasons for void in the bottom section of the form.
Block 2	**Provider ID Number** - If not preprinted, enter the seven-digit provider identification number assigned by the Medicaid Program.
Block 3	**Recipient ID Number** - Enter the 12-digit Medicaid eligibility number for the recipient receiving the service.
Block 3A	**Reference Number** - Enter the reference number for the claim being adjusting as it appears on the Remittance Voucher for the line of payment needing adjustment. The reference number follows the recipient's eligibility number on the Remittance Voucher. The adjustment cannot be made without this number.
Blocks 3B - 3C	Leave blank. For Fiscal Agent use only.
Block 4	**Recipient Name** - Enter the name of the recipient receiving the service.
Blocks 5 - 13	Omit Block 6 (it is not applicable to personal care services). If the information appearing in any of these blocks was incorrect on the original invoice, make the necessary corrections. To void the original payment, complete the adjustment invoice exactly as the original. When submitting an adjustment (DMAS-94) for an increase or a decrease in hours of service rendered, **do not submit** the difference in hours on the adjustment. Enter the **total number of hours of service given**; however, the hours cannot exceed the authorized hours.

Remarks Enter the date of the Remittance Voucher on which the original invoice was approved.

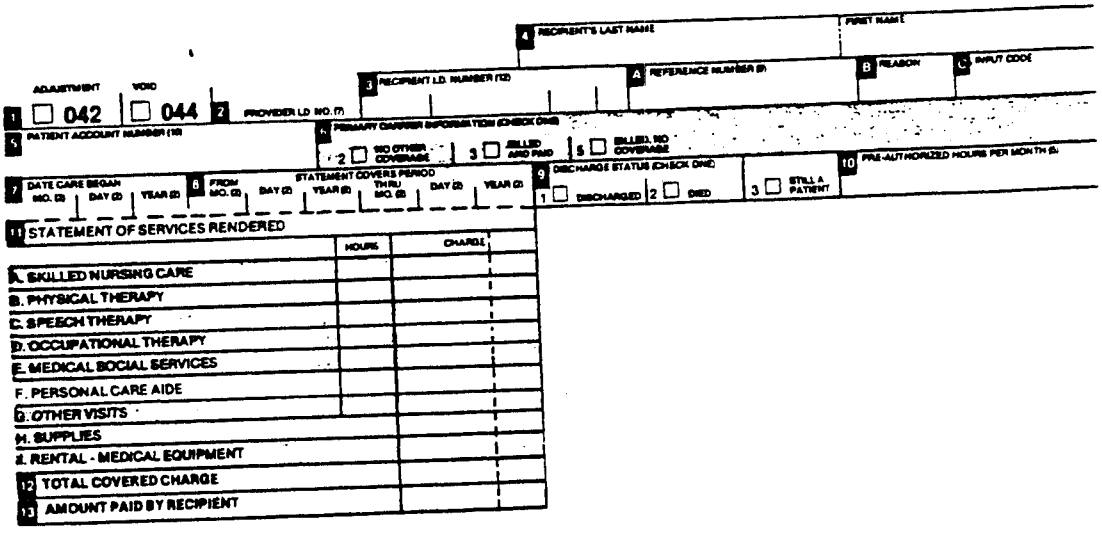
Signature and Date The person completing the form must sign the adjustment voucher. The date should be the date of mailing to the Fiscal Agent.

EXHIBIT VI.4

PERSONAL CARE INVOICE ADJUSTMENT (DMAS-94)

PERSONAL CARE INVOICE

MEDICAL ASSISTANCE PROGRAM



THIS FORM IS FOR CHANGING OR VOIDING A PAID ITEM. THE CORRECT REFERENCE NUMBER AS SHOWN ON THE REMITTANCE VOUCHER IS ALWAYS REQUIRED.

REMARKS:

_____ DATE OF REMITTANCE VOUCHER CLAIM WAS APPROVED

REASON FOR ADJUSTMENT:

____ CORRECTING AMOUNT PAID BY RECIPIENT
____ CORRECTING HOURS
____ CORRECTING CHARGES
____ CORRECTING DISCHARGE STATUS

ADJUSTMENT

REASONS FOR VOID:

____ USED INCORRECT RECIPIENT I.D. NUMBER
____ USED INCORRECT PROVIDER I.D. NUMBER
____ CORRECTING DATES OF SERVICE

THIS IS TO CERTIFY THAT THE FOREGOING INFORMATION IS TRUE, ACCURATE AND COMPLETE. I UNDERSTAND THAT PAYMENT AND SATISFACTION OF THIS CLAIM WILL BE FROM FEDERAL AND STATE FUNDS, AND THAT ANY FALSE CLAIMS, STATEMENTS, OR DOCUMENTS OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

_____ DATE
SIGNATURE

INTERMEDIARY COPY

INSTRUCTIONS FOR THE USE OF THE HCFA-1500 (12-90) BILLING FORM FOR RESPITE CARE SERVICES ONLY

To bill for services, the Health Insurance Claim Form, HCFA-1500 (12-90), invoice form must be used. The following instructions have numbered items corresponding to fields on the HCFA-1500. **The required fields to be completed are printed in boldface. Where more specific information is required in these fields, the necessary information is referenced in the locator requiring the information and provider-specific instructions are found on page 35.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), Billing Invoice

The purpose of the HCFA-1500 is to provide a form for participating providers to request reimbursement for covered services rendered to Virginia Medicaid recipients. (A sample of a completed HCFA-1500 claim form follows the instructions for its use.)

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box.**
1a	**REQUIRED**	**Insured's I.D. Number - Enter the 12-digit Virginia Medicaid Identification number for the recipient receiving the service.**
2	**REQUIRED**	**Patient's Name - Enter the name of the recipient receiving the service as it appears on the identification card.**
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Patient Status
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Other Insured's Date of Birth and Sex

Locator		Instructions
9c	NOT REQUIRED	Employer's Name or School Name
9d	NOT REQUIRED	Insurance Plan Name or Program Name
10	**REQUIRED**	**Is Patient's Condition Related To: - Enter an "X" in the appropriate box. (The "Place" is NOT REQUIRED.) a. Employment? b. Auto Accident? c. Other Accident? (This includes schools, stores, assaults, etc.)**
10d	**CONDITIONAL**	**Enter "ATTACHMENT" if documents are attached to the claim form or if procedure modifier "22" (unusual services) is used.**
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Employer's Name or School Name
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	NOT REQUIRED	Date of Current Illness, Injury, or Pregnancy
15	NOT REQUIRED	If Patient Has Had Same or Similar Illness
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**CONDITIONAL**	**Name of Referring Physician or Other Source**
17a	**CONDITIONAL**	**I.D. Number of Referring Physician - Enter the 7-digit Virginia Medicaid number of the referring physician. See the following pages for special instructions for your services.**
18	NOT REQUIRED	Hospitalization Dates Related to Current Services
19	NOT REQUIRED	Reserved for Local Use
20	NOT REQUIRED	Outside Lab?

Locator		Instructions
21	REQUIRED	Diagnosis or Nature of Illness or Injury - Enter the appropriate ICD-9 CM diagnosis which describes the nature of the illness or injury for which the service was rendered.
22	CONDITIONAL	Medicaid Resubmission - Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	NOT REQUIRED	Prior Authorization Number
24A	REQUIRED	Dates of Service - Enter the from and thru dates in a 2-digit format for the month, day, and year (e.g., 04/01/92). DATES MUST BE WITHIN THE SAME CALENDAR MONTH.
24B	REQUIRED	Place of Service - Enter the 2-digit HCFA code which describes where the services were rendered. See the Place of Service Codes list following the instructions for the appropriate code entry.
24C	REQUIRED	Type of Service - Enter the one-digit HCFA code for the type of service rendered. See the code list following the instructions for the appropriate code entry.
24D	REQUIRED	Procedures, Services or Supplies CPT/HCPCS - Enter the 5-character CPT/HCPCS Code which describes the procedure rendered or the service provided. See the attached code list for special instructions if appropriate for your service. Modifier - Enter the appropriate HCPCS/CPT modifiers if applicable. See the list of modifiers following the instructions for the appropriate entry.
24E	REQUIRED	Diagnosis Code - Enter the entry identifier of the ICD-9CM diagnosis code listed in Locator 21 as the primary diagnosis. NOTE: Only one code is processable.
24F	REQUIRED	Charges - Enter your total usual and customary charges for the procedure/services. See the special instructions following these instructions if applicable for your service.

Locator		Instructions
24G	REQUIRED	Days or Unit - Enter the number of times the procedure, service, or item was provided during the service period. See the pages following the instructions for special instructions if applicable to your service.
24H	CONDITIONAL	EPSDT or Family Plan - Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I	CONDITIONAL	EMG (Emergency) - Place a "1" in this block if the services are emergency-related. Leave blank if not an emergency.
24J	REQUIRED	COB (Primary Carrier Information) - Enter the appropriate code. See special instructions if required for your service. 2 - No Other Carrier 3 - Billed and Paid 5 - Billed, No Coverage
24K	REQUIRED	Reserved for Local Use - Enter the dollar amount received from the primary carrier if Block 24J is coded "3". See special instructions if required for your service.
25	NOT REQUIRED	Federal Tax I.D. Number
26	OPTIONAL	Patient's Account Number - Seventeen alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	NOT REQUIRED	Total Charge
29	NOT REQUIRED	Amount Paid
30	NOT REQUIRED	Balance Due

Locator		Instructions
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials - The provider or agent must sign and date the invoice in this block.**
32	NOT REQUIRED	Name and Address of Facility Where Services Were Rendered
33	**REQUIRED**	**Physician's, Supplier's Billing Name, Address ZIP Code & Phone # - Enter the provider's billing name, address, ZIP Code, and phone number as they appear in your Virginia Medicaid provider record. Enter your 7-digit Virginia Medicaid provider number in the PIN # field. Ensure that your provider number is distinct and separate from your phone number or ZIP Code.**

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as an Adjustment Invoice

The Adjustment Invoice is used to change information on a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 Medicaid Resubmission

Code - Enter the 3-digit code identifying the reason for the submission of the adjustment invoice.

523 Primary Carrier has made additional payment
524 Primary Carrier has denied payment
525 Accommodation charge correction
526 Patient payment amount changed
527 Correcting service periods
528 Correcting procedure/service code
529 Correcting diagnosis code
530 Correcting charges
531 Correcting units/visits/studies/procedures
532 IC reconsideration of allowance, documented
533 Correcting admitting, referring, prescribing, provider identification number

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each HCFA-1500 submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim.)

Instructions for the Completion of the Health Insurance Claim Form, HCFA-1500 (12-90), as a Void Invoice

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, HCFA-1500 (12-90), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 3-digit code identifying the reason for the submission of the void invoice.

542 Original claim has multiple incorrect items
544 Wrong provider identification number
545 Wrong recipient eligibility number
546 Primary carrier has paid DMAS maximum allowance
547 Duplicate payment was made
548 Primary carrier has paid full charge
551 Recipient not my patient
552 Void is for miscellaneous reasons
560 Other insurance is available

Original Reference Number - Enter the 9-digit claim reference number of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each HCFA-1500 submitted as a Void Invoice. (Each line under Locator 24 is one claim.)

PLACE OF SERVICE CODES

HCFA-1500 CODE	
00-10	Unassigned
11	Office location
12	**Patient's home**
13-20	Unassigned
21	Inpatient hospital
22	Outpatient hospital
23	Emergency room
24	Ambulatory surgical center
25	Birthing center
26	Military treatment center
27-30	Unassigned
31	Skilled nursing facility
32	Nursing facility
33	Custodial care facility
34	Hospice
35-40	Unassigned
41	Ambulance - land
42	Ambulance - air or water
43-50	Unassigned
51	Inpatient psychiatric facility
52	Psychiatric facility - partial hospitalization
53	Community mental health center
54	Intermediate care facility/mentally retarded
55	Residential substance abuse treatment facility
56	Psychiatric residential treatment center
57-60	Unassigned
61	Comprehensive inpatient rehabilitation facility
62	Comprehensive outpatient rehabilitation facility
63-64	Unassigned
65	End stage renal disease treatment facility
66-70	Unassigned
71	State or local public health clinic
72	Rural health clinic
73-80	Unassigned
81	Independent laboratory
82-98	Unassigned
99	Other unlisted facility

TYPE OF SERVICE CODES

CODE	DESCRIPTION
1	**Medical care**
2	Surgery
3	Consultation
4	Diagnostic x-ray
5	Diagnostic laboratory
6	Radiation therapy
7	Anesthesia
8	Assistance at surgery
9	Other medical care
0	Blood or packed red cells
A	Used DME
F	Ambulatory surgical center
H	Hospice
L	Renal supplies in the home
M	Alternate payment for maintenance dialysis
N	Kidney donor
V	Pneumococcal vaccine
Y	Second opinion on elective surgery
Z	Third opinion on elective surgery

SAMPLE

COMPLETED HEALTH INSURANCE CLAIM FORM (HCFA-1500) AS A VOID INVOICE

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

APPROVED OMB-0938-0008

PICA

HEALTH INSURANCE CLAIM FORM

PICA

MEDICARE | MEDICAID | TRICARE/CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER

1. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)

(Medicare #) X (Medicaid #) (Sponsor's SSN) (VA File #) (SSN or ID) (SSN)

544519000122

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

Lee, May

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY

STATE

8. PATIENT STATUS Single Married Other

CITY

STATE

ZIP CODE

TELEPHONE (Include Area Code) ( )

Employed Full-Time Student Part-Time Student

ZIP CODE

TELEPHONE (INCLUDE AREA CODE) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES X NO

b. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. OTHER INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. AUTO ACCIDENT? YES X NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? YES X NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED

DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM 24E BY LINE)

1. 461 1

2. 466 1

3.

4.

22. MEDICAID RESUBMISSION CODE 544 ORIGINAL REF. NO. 111111111

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
05 01 94	05 01 94	11	1	99212		1	25 00	1			3	$15.00

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO. 12345678

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. BALANCE DUE $

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED John Jones DATE 2/2/94

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

(804) 999-9999

John Jones, MD
23 Main Street
Town, VA 99999

PIN# 1234567

GRP#

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)

SPECIAL BILLING INSTRUCTIONS

CLIENT MEDICAL MANAGEMENT PROGRAM

The primary care physician bills for services in the usual manner, but other physicians must follow special billing instructions to receive payment. Covered outpatient services excluded from this requirement include: renal dialysis clinic services, routine vision care services, BabyCare services, personal care services (respite care or adult day health care), ventilator-dependent services, EPSDT, and prosthetic services.

All services should be coordinated with the primary health care provider whose name appears on the recipient's eligibility card. Other DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

A physician treating a restricted recipient as a physician covering for the primary care physician or on referral from the primary care physician must place the primary care physician's Medicaid provider number (as indicated on the recipient identification card) in Locator 17a and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice.

In a medical emergency situation, if the practitioner rendering treatment is not the primary care physician, he or she must certify that a medical emergency exists for payment to be made. The provider must enter a "1" in Locator 24I and attach an explanation of the nature of the emergency.

LOCATOR	SPECIAL INSTRUCTIONS
10d	Write "ATTACHMENT" for the Practitioner Referral Form, DMAS-70, or for remarks as appropriate.
17a	When a restricted recipient is treated on referral from the primary physician, enter the primary care physician's Medicaid provider number (as indicated on the card) and attach a copy of the Practitioner Referral Form (DMAS-70) to the invoice. Write "ATTACHMENT" in Locator 10d.
24I	When a restricted recipient is treated in an emergency situation by a provider other than the primary physician, the non-designated physician enters a "1" in this Locator and explains the nature of the emergency in an attachment. Write "ATTACHMENT" in Locator 10d.

SPECIAL BILLING INSTRUCTIONS

MEDALLION

Primary Care Providers (PCP) bill for services on the Health Insurance Claim Form, HCFA-1500 (12-90). The invoice is completed and submitted according to the instructions provided in the Medicaid Physician Manual.

To receive payment for their services, referral providers authorized by a client's PCP to provide treatment to that client must place the Medicaid Provider Identification Number of the PCP in Locator 17a of the HCFA-1500. Subsequent referrals resulting from the PCP's initial referral will also require the PCP Medicaid provider number in this block.

SPECIAL BILLING INSTRUCTIONS

RESPITE CARE SERVICES

Locator 24D — **Procedures, Services or Supplies**

CPT/HCPCS - Enter the appropriate procedure code from the following list.

CODE	DESCRIPTION
Z9421	Respite care services, aide/hr.
Z9422	Respite care services, aide/day
Z9423	Respite care services, LPN/hr.
Z9424	Respite care services, LPN/day

Locator 24J — **COB (Primary Carrier Information)**

3 - Billed and Paid (Use for patient pay.)

Locator 24K — **Reserved for Local Use**

Enter the patient pay amount if applicable.